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Missouri Division of Medical Services

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Optical Bulletin

Provider Communications
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MC+ MANAGED CARE PROGRAM

MC+ managed care health plans provide optical benefits to their enrollees. Coverage of optical services under MC+ managed care is the same as for fee-for-service.

Billing requirements outlined in this bulletin apply to services provided to MC+ and Medicaid recipients who receive their services on a fee-for-service basis.

Check with the MC+ managed care health plans for their billing requirements.

2002 CPT AND HCPCS UPDATES

On July 16, 2002, Verizon updated the file to begin accepting the 2002 versions of the *Current Procedural Terminology* (CPT) and the 2002 *Health Care Procedure Coding System* (HCPCS). The 2002 procedure codes have an effective date of July 1, 2002. Providers have a 60 day transition period to allow time to make the necessary changes. Providers may bill a 2001 code for a 2002 date of service until September 1, 2002. Claims for dates of service on or after September 1, 2002 must contain only those active procedure codes found in the 2002 CPT book (Level I codes) or the 2002 HCPCS book (Level II codes). Claims for dates of service prior to July 1, 2002 must contain only those procedure codes found in the 2001 CPT or HCPCS books.

Changes which occurred as a result of HCPCS updating were: procedure code deletions; replacement procedure codes; and the addition of new procedure codes.

A copy of the 2002 version of the *Current Procedural Terminology* and *2002 Health Care Procedure Coding System* may be purchased from your local medical book store.

2002 PROCEDURE CODES ADDED

The following HCPCS Level II procedure codes and CPT procedure code have been added. The amount shown is the Maximum Allowed Amount for the procedure code.

G0117 (*Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist*) - $24.87. When billing procedure code G0117, providers can not bill for any other office visit procedure code or eye examination procedure code on the same date of service.

G0118 (*Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist*) - $17.48. When billing procedure code G0118, providers can not bill for any other office visit procedure code or eye examination procedure code on the same date of service.

92136 (*Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation*) - $36.36.

S0580RT (*Polycarbonate lens, right eye [RT]*) - $15.00. Completed Medical Necessity form required with the claim. May be billed in addition to the appropriate refractive lens, on the same date of service.

S0580LT (*Polycarbonate lens, left eye [LT]*) - $15.00. Completed Medical Necessity form required with the claim. May be billed in addition to the appropriate refractive lens, on the same date of service.

S0581RT (*Nonstandard lens, right eye [RT]*) - Manually priced. May be billed in addition to the appropriate refractive lens. The invoice of cost for the lens and a completed Medical Necessity form required with claim.

S0581LT (*Nonstandard lens, left eye [LT]*) - Manually priced. May be billed in addition to the appropriate refractive lens. The invoice of cost for the lens and a completed Medical Necessity form required with claim.

S0592 (*Comprehensive contact lens/lenses evaluation*) - $20.00. Covered for recipients age 0-20. This procedure code may be billed in addition to an eye exam (same date of service) when the patient needs contact lens/lenses with corrective power for visual improvement. It is only payable if the reason for the contacts meets our guidelines for contact lens/lenses.

CONTACT LENS WITH CORRECTIVE POWER

Contact lenses with corrective power are *only* covered for recipients age 0-20 for medical reasons such as keratoconus, aphakia, or anisometropia of 4.00 diopters or greater. The contact lens should be billed using procedure code Y4049 (Special lens [1]) or Y4050 (Special lens [2]). A Medical Necessity form and the invoice of cost are required with the submitted claim.

PROCEDURE CODES WITH MODIFIERS

When a procedure code lists a modifier, the modifier must be used with the procedure code on the claim form. Without the modifier, the procedure code will deny as not covered.

POLYCARBONATE LENS/LENSES

Polycarbonate lens/lenses are only covered for certain conditions when the eye(s) need extra protection. Examples of these conditions are:

- Recipient needs protection of their good eye because they are legally blind in the other eye.
- Recipient has a medical condition such as seizures. A seizure could cause the recipient to fall down and break the lens/lenses which might injure their eyes.

A Medical Necessity form must be sent with the claim explaining why the polycarbonate lenses are needed.

PRIOR AUTHORIZATION REMOVED

Prior authorization has been removed from the following procedure codes:

V2744 (*Photochromatic tint, per lens*),

92081 (*Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot,*

arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent),

92082 (*Visual field examination, unilateral or bilateral, with interpretation and report*; *intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey, suprathreshold automatic diagnostic test, Octopus program 33*), and Y4011 (*Special frames*) A completed MN is required with the claim when billing for this procedure code.

BILLING REMINDER

The optical prescription for procedures Y4049 and Y4050 must be written in minus cylinder in Field 19 on the claim form and on the Medical Necessity form.